

Commission on Enhancing Agency Outcomes

Proposal to Take Advantage of Federal Assistance to Veterans

Current Federal Health Care System for Veterans. Connecticut has over 277,000 veterans.¹ The federal Department of Veterans Affairs, through the Veterans Health Administration, operates a system that includes 153 medical centers, 882 ambulatory care and community-based outpatient clinics, 207 Vet Centers,² 136 nursing homes, 45 residential rehabilitation treatment programs, and 92 comprehensive home-based care programs. Health care assistance for veterans includes inpatient hospital care, outpatient care, laboratory services, pharmaceutical dispensing, and mental health counseling. In addition to VA-run nursing homes, the VA also operates a community nursing home program, which allows some level of patient choice in selecting a nursing home close to the veteran's home and family, and quality assurance through regular visits by VA health care facility staff.

Connecticut's federally supported VA system has an inpatient facility and ambulatory care center (West Haven), an ambulatory care center (Newington), six primary care community based outpatient clinics (Danbury, New London, Stamford, Waterbury, Windham, and Winsted), and four Vet Centers (Danbury, Norwich, Rocky Hill, and West Haven). A Veterans Benefits Administration regional office is located in Newington, and intake sites are at the US Naval Submarine Base New London at Groton, and at the New London Coast Guard Academy.

The Veterans' Health Care Eligibility Reform Act of 1996 expanded the population of veterans eligible for VA hospital care and medical services. Historically a health care system covering only veterans with service-connected disabilities, under current VA rules, *the VA Medical Benefits package is now open to all veterans who served honorably for two years in a branch of the military.* To receive VA health care benefits, a veteran must enroll in the VA health care system (using VA Form 10-10EZ). Veterans are then categorized into one of eight priority groups (see Appendix A for a description of the priority groups). Priority Group 5, for example, includes any veteran (and spouse) who is eligible for Medicaid.

VA health benefits are established by federal law and regulations, and are funded through appropriations; **they are not considered an entitlement.** Although dependent upon how much Congress approves for VA benefits in a given year, priority group 5 veterans have never lost their benefits.³

How Many Veterans are Receiving Medical Benefits from VA? There are 7.9 million veterans nationwide currently receiving VA benefits. There are an additional approximately 5.8 million veterans who meet eligibility requirements in priority groups 1-7 for medical care from the VA health system who are not enrolled. Based on these figures, *just 58 percent of eligible veterans are actually enrolled in the VA health system.*

In Connecticut, there are 52,000 veterans receiving medical benefits from the VA, and 27,000 of them have service-connected disabilities.⁴

¹ Testimony provided by Commissioner of Department of Veteran's Affairs at 3/2/10 public hearing of VA Committee. The U.S. Census Bureau 2006-2008 American Community Survey 3-Year Estimates identified 246,572 civilian veterans in Connecticut.

² Vet Centers provide counseling and other services to help veterans and their families make a successful post-war adjustment in their community.

³ According to 10/13/10 telephone conversation with aide in Senator Lieberman's office.

Potential barriers to receipt of medical benefits from VA include:

- challenges in the process for transitioning active duty service members from TRICARE (health care system operated by the Department of Defense) into the VA health care system (operated by the Department of Veterans Affairs),
- inconvenient distance to VA health care sites, and
- lack of awareness that such benefits are available to the veteran.

Veterans Receiving Medicaid Benefits. Prompted by challenging financial times, at least 20 states are examining whether veterans currently receiving state-funded Medicaid, may also qualify for federally-funded veterans benefits. Many states have reported that veterans did not realize they qualified for federal veterans benefits, which could provide them with less expensive co-pays for prescription drugs and other health care advantages.

The California Legislative Analyst's Office recently conducted a study of military veterans in California⁵ and concluded that there were approximately 144,000 veterans and their family members receiving state-funded Medicaid (Medi-Cal) who could be receiving comprehensive federally-funded medical benefits from the VA. In comparing Medi-Cal with the federal veterans medical benefits, the analysts concluded that *VA medical benefits were often better* than those provided by Medi-Cal because:

- there is greater access to mental health counseling and treatment for alcohol and substance abuse;
- the VA does not place a cap on the cost of dental services;
- the VA does not limit the number of days per year a patient can be hospitalized;
- unlike Medi-Cal, the VA system does not require a beneficiary to pay down assets to become "medically needy" before covering the costs of long-term care; and
- the VA has greatly improved accessibility and wait time (e.g., waiting time for cardiovascular procedures was significantly shorter through the VA than through Medicaid (and Medicare)).

Veterans May Receive Health Care from Multiple Sources. In a report issued by the Congressional Budget Office,⁶ it was noted that veterans may receive medical services from the VA and/or other sources such as Medicare, Medicaid, private health insurance, the military system, or public hospitals. The report further noted that reliance on VA for medical needs varied across the veteran priority groups. For example, low-income veterans in priority group 5 (i.e., Medicaid-eligible) receive approximately 43 percent of their medical care from the VA.

Because enrollment in other health coverage does not preclude receipt of VA health benefits, the veteran may belong to multiple health plans, and have the flexibility to use services from an array of sources. Further, under federal law, Medicaid is intended to be the payor of last resort, meaning that other available sources such as the VA must be exhausted before Medicaid can provide services.

Identification of Veterans Receiving Medicaid. The CT DSS eligibility determination form requires applicants to self-report information about household members who are veterans, including receipt of veterans benefits. The number of Medicaid recipients who had self-reported veteran status during the application process is unknown by DSS at this time.

In addition to self-reporting of veteran status during the DSS eligibility application process, a 17-year-old federal computer data matching system (originally developed to prevent welfare recipients from drawing benefits in more than one state at a time), the **Public Assistance Reporting Information System**

⁴ Telephone conversation with DVA Commissioner Schwartz

⁵ Data Match Increases Veterans' Access to Benefits and Reduces State Costs, California Legislative Analyst's Office, Analysis of the 2007-08 Budget Bill.

⁶ The Health Care System for Veterans: An Interim Report, December 2007, Congressional Budget Office.

(PARIS), allows states to identify people who are simultaneously enrolled in state and federal health and social services programs. States may then shift medical care for veterans to the federal government thereby eliminating the state match required for Medicaid. Use of the PARIS system had been optional. However, in October 2009, in an effort to reduce Medicaid fraud, Congress required Connecticut and other states to use PARIS as a requirement for their receipt of CMS funding for automated data systems.

Connecticut's Department of Social Services (DSS) Fraud & Recoveries area has used the PARIS match information to identify individuals receiving both Medicaid and veterans benefits, resulting in reductions or closure of Medicaid benefits. Since 2004, PARIS matches have identified 2,627 cases in Connecticut with discrepancies in information reported by DSS beneficiaries who were also receiving veterans benefits. Subsequent investigation by the DSS Fraud & Recoveries area led to reductions or elimination of \$407,766 in all DSS benefits (not just Medicaid) for 638 cases (24 percent).

DMHAS has indicated informally to DVA Commissioner Schwartz that DMHAS provides services for over 7,000 veterans. However, due to confidentiality issues, DMHAS will not share this information with DVA.⁷

A Memorandum of Agreement entered into spring 2009 between CT DVA and DSS:

1. allows DSS, on a quarterly basis, to send electronic reports to CT DVA containing lists of DSS clients deemed by DSS to either receive or be eligible for benefits from DSS and the federal Department of Veterans Affairs;
2. specifies that CT DVA shall further research eligibility, and apply for federal benefits for the veteran and his/her dependents as appropriate; and
3. specifies that CT DVA is to report back monthly to DSS on the status of benefits.

In May 2009, DSS produced an initial file for DVA containing information on 2,508 individuals receiving both veterans and DSS benefits. (DSS has not yet provided DVA with information on DSS recipients who identify themselves as veterans during the DSS benefit application process, but who were not receiving veterans benefits.)

DVA reported that nothing has been done with this initial list. DSS reported that it has been discussing the mechanics of the data-sharing with DVA as recently as November 1, 2010; however, no further progress has been made to use the information provided by the PARIS match and names of DSS beneficiaries not currently receiving veterans benefits.

Examples of Savings Other States Experienced. Several states have begun using the PARIS match information to transfer veterans to VA or Department of Defense benefits. Some examples are:

- Montana (101,584 veterans)⁸ saved \$1 million in fiscal year 2008 and anticipated a savings of \$1.9 million in fiscal year 2009 by transferring veterans from Medicaid to the military's TRICARE health system.
- Washington state, with an estimated 618,086 veterans⁸ has transferred over 3,500 veterans and their families, many in long-term care, from Medicaid to either Department of Defense or VA healthcare coverage, saving \$20 million since 2006, including \$4.9 million in the most recent fiscal year
- California, with an estimated 2,086,560 veterans⁸ identified 144,000 state Medicaid recipients in 2007 who were veterans, and eligible for benefits from the Veterans Health Administration; annual savings of \$250 million from a voluntary shift of veterans from Medicaid to VA healthcare were estimated
- Colorado began using the PARIS match information and identified 1,600 VA-benefit eligible individuals or families, estimated to potentially save \$8 million annually

⁷ PRI interview with Commissioner Schwartz on October 5, 2010.

⁸ U.S. Census Bureau 2006-2008 American Community Survey 3-Year Estimates.

Washington State. When the PARIS match was originally launched in 2003 in Washington State, just three percent of long-term care patients were identified as veterans, even though data showed the figure should have been over 40 percent (The Washington Department of Veterans Affairs estimated that 50 percent of all males 65 years of age and older are veterans). The lower percentage was due primarily to: 1) reliance on self-identification or identification by the veteran's family, 2) confusion about what benefits the VA actually provided, and 3) lack of clarity regarding who qualified for VA benefits. Washington state now sends their DVA—on a weekly basis—a list of Medicaid recipients who were recently approved for long-term care, and 42-43 percent are consistently found to be veterans (and thus eligible for federal VA benefits). Washington State also:

- used the PARIS database to identify veterans receiving no benefits (\$0), often due to the veteran failing to turn in an eligibility review form, with the benefits subsequently cancelled by the VA. Washington State now reaches out to these \$0 cases and helps veterans file the necessary forms;
- began using the PARIS database to identify veterans receiving \$90 per month from the VA. This dollar amount was a flag that the veteran had been receiving a VA pension (as high as \$1,700 per month), which was then reduced to \$90 upon entry into a nursing home. However, for veterans who left nursing home care to return to the community and receive in-home care, the higher VA pension should have been reinstated, allowing the veteran to contribute to their state-funded care; and
- stopped paying prescription drug claims for 200 Medicaid clients living in two veteran nursing facilities, shifting veterans to the VA prescription drug plan, and saving approximately \$1 million annually.

Investment in Identification and Receipt of Federal VA Benefits for Veterans. As noted, the state of Washington is the originator of the effort to identify and transfer eligible veterans from Medicaid to federal VA medical benefits. Since 2006, that state's efforts in identifying and transferring veterans from Medicaid to federal VA coverage have resulted in a savings of \$20 million. The **resources** required for this effort were **two staff to identify the veterans** using PARIS match information, and **two to three state Department of Veterans Affairs staff** to help the veterans apply for and transition to the federal VA program.

California researched the experience of other states, including New York and Pennsylvania, and estimated it would require **approximately \$200,000 for two additional staff members and related operating support** to implement a program similar to that of Washington state.

Due in part to inadequate resources to reach potential beneficiaries, Kansas estimates just 14 percent of its 10,400 veterans (1,500) eligible for benefits currently receive them. Kansas further estimates that its proposed veterans' benefit enhancement program (based on PARIS match information) will **cost approximately \$225,000.**

Connecticut resources. Based on the experiences of other states, **approximately two DSS staff** would be needed to review the PARIS match and analyze the results to identify veterans potentially eligible for VA benefits. Current DSS efforts pertaining to the PARIS match occur in the Fraud and Recoveries area, with a focus on identifying whether income from the VA was accurately reported by DSS beneficiaries. Instead of identifying fraud, Washington State, for example, focuses on the matches as an opportunity to offer additional, better services, and at the same time, save the state money.

Additionally, there are veterans who receive Medicaid and are not receiving any veterans benefits, and thus will not appear on the PARIS match. Efforts to identify these veterans and shift some or all of their

benefits to the federal VA program, would save Connecticut the money spent on the 50 percent match required by the state Medicaid program.

Interviews with the Connecticut DVA have highlighted significant resource limitations, particularly following the RIP retirements (although the manager of veteran advocacy and assistance position was recommended and approved for refill (which occurred July 2010)). The CT DVA reports vacancies in the Office of Assistance and Advocacy for three veterans services officer positions. In the Bridgeport region alone, for example, there are two veterans services officer vacancies, leaving just one veterans service officer to do outreach for the entire Bridgeport region. The **CT DVA would most likely need one to two additional staff** dedicated to outreach and assistance in linking veterans with eligible benefits from the federal VA. Some states subcontract with veterans groups, such as the VFW, to assist in outreach to veterans, an option Connecticut might also wish to consider.

Communication between DSS and DVA is critical to the success of such an initiative. As a result of the RIP, both agencies lost key staff most familiar with the PARIS match and the agencies need to:

- develop a better understanding of the purpose and frequency of the PARIS match,
- what the resulting information means,
- the filtering and identification of particular veterans, and
- provision of the information in a format that is usable by DVA.

Not only will these efforts result in financial savings to Connecticut, but veterans will gain additional support beyond what they currently receive.

If Connecticut was to have an experience similar to that of Washington state and Montana, then, with a minimal investment of \$200,000-\$250,000 in adequate staffing, the state could expect to save approximately **\$2 million** in the first year, and more in subsequent years.

Finally, better sharing of veteran's information among all agencies who potentially could be serving veterans is needed. The Department of Mental Health and Addiction Services, for example, purportedly provides services to over 7,000 veterans; however, there has been a reluctance to share this information with DVA due to confidentiality issues.⁹ Just as there is a memorandum of agreement between DSS and DVA to share information, a similar agreement between DVA and DMHAS (and perhaps DVA and other agencies serving veterans) would further efforts to help veterans gain additional benefits to which they are entitled, and result in financial savings to Connecticut's budget.

⁹ PRI interview with Commissioner Schwartz on October 5, 2010.

APPENDIX A

Eligibility Requirements for VA Medical Benefits Priority Groups	
Priority Group	Eligibility Requirements
1	<ul style="list-style-type: none"> • Veterans with service-connected disabilities rated 50% or more disabling • Veterans determined by VA to be unemployable due to VA service-connected conditions
2	<ul style="list-style-type: none"> • Veterans with service-connected disabilities rated 30% or 40% disabling
3	<ul style="list-style-type: none"> • Veterans who are former prisoners of war • Veterans awarded the Purple Heart Medal • Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty • Veterans with VA service-connected disabilities rated 10% to 20% disabling • Veterans disabled by treatment or vocational rehabilitation provided by the VA
4	<ul style="list-style-type: none"> • Veterans who are receiving aid and attendance benefits (cash payments from VA to eligible individuals who need assistance with daily activities because of a disability) or are housebound • Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> • 0% disabled veterans whose annual income and net worth are below the established VA Means Test thresholds • Veterans receiving VA pension benefits • Veterans who are eligible for Medicaid benefits
6	<ul style="list-style-type: none"> • World War I or Mexican Border War veterans • Veterans seeking care solely for disorders associated with exposure in the line of duty to chemical, nuclear, or biological agents (e.g., Agent Orange) • Compensable 0% service-connected Veterans • Combat veterans who are within the two-year special eligibility period
7	<ul style="list-style-type: none"> • Non-disabled veterans who have income and/or net worth <u>above</u> VA's means-test thresholds and <u>below</u> a geographic index defined by the Department of Housing and Urban Development
8	<ul style="list-style-type: none"> • Non-disabled veterans who have income and/or net worth <u>above</u> VA's means-test thresholds and <u>above</u> a geographic index defined by the Department of Housing and Urban Development • (Enrollment in this priority group has been frozen since January 2003; however, recent combat veterans may enroll during a two-year special eligibility period regardless of disability or income status)
Source: United States Department of Veterans Affairs (http://www4.va.gov/healtheligibility/library/pubs/healthcareoverview/)	